STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155673	B. WING		07/12/2012
				ADDRESS, CITY, STATE, ZIP CODE	I.
NAME OF	PROVIDER OR SUPPLIE	SR .	170 N T	RACY ST	
MARKLE	E HEALTH & REHA	ABILITATION	MARKL	E, IN 46770	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was f	or the Recertification and	F0000		
			10000		
	State Licensure	Survey.			
	Survey Dates:	7/8-7/12/12			
	Survey Dates.	7/0-7/12/12			
	Facility number	·· 000544			
	Provider number				
	AIM number::				
	7 HIVI Humber	100207540			
	Survey Team:				
	Shelley Reed R	N TC			
	Julie Call RN				
	Linn Mackey R	N			
	Virginia Tervee				
	Viiginia Tervee	i Kiv			
	Census Bed Typ	ne:			
	SNF/NF 78	ρ C .			
	Total: 78				
	Total. 76				
	Census Payor T	vne:			
	Medicare: 7	ype.			
	Medicaid: 51				
	Other: 20				
	Total: 78				
	10141. /0				
	These deficience	ies also reflect state			
		accordance with 410 IAC			
	16.2.	i accordance with 710 I/1C			
	10.2.				
	Quality review	completed 7/19/12			
	Cathy Emswille	-			
	Camy Emswine	N ICI			
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
MARKLE	HEALTH & REHA	BILITATION		ΓRACY ST .Ε, IN 46770	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

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, ,		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155673	B. WING		07/12/2012
	PROVIDER OR SUPPLIEF		170 N	ET ADDRESS, CITY, STATE, ZIP CODE N TRACY ST KLE, IN 46770	
(X4) ID	SUMMARY S	MMARY STATEMENT OF DEFICIENCIES			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
F0223 SS=D	SECLUSION The resident has verbal, sexual, p corporal punishr seclusion. The facility must sexual, or physic punishment, or i Based on interreview, the fac residents were abuse for 1 of residents reviein a sample of Findings including in a sample of Findings including incl	s the right to be free from physical, and mental abuse, ment, and involuntary a not use verbal, mental, cal abuse, corporal involuntary seclusion. View and record illity failed to ensure free from physical 14 interviewed wed for physical abuse 40. (Resident #98) de: with Resident #98 on 106 A.M., the Resident wanted to get the sit in the chair. The ed due to previously the chair for a 3 hour ent #98 indicated the experience as a second resident wanted to get the sit in the chair. The ed due to previously the chair for a 3 hour ent #98 indicated the experience as a second resident roughly to ident #98 was unable staff member or when curred. Indicated the incident ed and wanted the	F0223	F223It is the practice of this facility to ensure each reside has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, & involuntary seclusion. It is also the pract of this facility to ensure verbal mental, sexual, or physical and corporal punishment, or involuntary seclusion is not used. I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility management immediately suspended an employee, pending further investigation of the allegation. Upon completion of a thorougin investigation, the allegation of the employee was permit to return to work. Upon conclusion of the investigation facility management submitter Follow-Up Report to ISDH or 7-13-12. II. How will other residents having the potential be affected by the same defining the potential be affect	tice al, buse, on(s) se on t n. gh vas iated itted on, ed a on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155673	B. WING 07/12/20			07/12/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	
MARKE		DILITATION!			FACY ST	
MARKLE	HEALTH & REHA	BILITATION		MARKL	E, IN 46770	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	incident in an interview on 7-9-2012				corrective action(s) will be	
	at 11:29 A. M.				taken: Employees were	
					re-educated on abuse & negle	
	Resident #08's	clinical record was			policy. The all-staff inservice	
		10-2012 at 3:17 P.M.			be conducted by DNS/designe	
	Teviewed Off 7-	10-2012 at 3.17 F.W.			completed by 8-11-12.III. What measures will be put into place	
					what systemic changes will be	
		diagnoses included			made to ensure that the deficie	l l
		ted to meningioma,			practice does not recur: Memb	l l
	hypertension, a	anemia, hyperlipidemia,			of the IDT team will conduct	
	dyspnea, fatigue, seizure disorder, insomnia, gastrointestinal reflux disease, COPD (chronic obstructive				resident interviews using the	
					questions in section G (Abuse)
					listed on the CMS form titled	
		ease, CHF (congestive			Resident Interview & Resident	
		depression, coronary			Observation. Interviews will be	
	· · · · · · · · · · · · · · · · · · ·	•			conducted on all "interviewable	9"
	artery disease,	weight ioss.			residents by 8-11-12. Any negative findings will be	
	D = = : d = = + #00 =				immediately reported to the	
		scored a 15 of 15 for			facility Administrator/DNS &	
		ew mental status			investigated. During the mont	hly
	(BIMS) on the	Minimum Data Set			resident council meetings, the	'
	assessment (M	1DS) dated 5-9-2012,			Administrator or another invite	d
	6-19-2012 and	6-24-2012.			IDT member will encourage	
					residents to voice any concerr	
	On 7-11-2012	at 12:00 P.M., a review			they may have regarding abus	e,
		estigation report			mistreatment, or	_
		eport was initiated on			misappropriation. IDT member will be responsible to conduct	S
		•			monthly Family Interviews. At	the
		ugh treatment to			time of each interview, the IDT	
		vas reported to			member will complete the CMS	
	administrator.				form titled Family Interview.	
					Family interviews will be	
	A copy of the e	e-mail subject page			conducted in conjunction with	our
	indicated the in	nitial report was			already established Customer	
	transmitted to ISDH (Indiana State				Care program & are done	
		Health) on 7-9-2012 at			monthly.IV. How will the	
		•			corrective action(s) be monitor	
		faxed to APS (Adult			to ensure the deficient practice	l l
	Protective Ser	vices) on 7-9-2012 at			will not recur, i.e., what quality	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155673	B. WIN			07/12/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8					
MADIZIE	LICALTILO DELLA	OIL ITATION			FACY ST		
WARKLE	HEALTH & REHA	BILITATION		WARKL	E, IN 46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1:48 P.M., and	faxed to			assurance program will be put		
	the Ombudsma	an on 7-9-12 at 8:34			into place: DNS/designee will be		
	P.M.				responsible for completion of t	he	
					CQI tool titled "Resident		
					Interview". The audit tool will l	be	
	1	owed it's policy and			completed weekly x 4 weeks,		
	· •	he investigation of			then monthly x 6 months. Tre		
	physical abuse	, which included but			or findings will be submitted to	ine	
	was not limited	to:			CQI committee for review & follow-up.V. By what date will		
					systemic changes be complete		
	a) The Admini	strator and Social			8-11-12		
	Service Director interviewed the resident.						
	resident.						
	l '	assessment was					
	completed on F	Resident #98 and no					
	injuries were no	oted.					
	c) The son wa	as notified of the rough					
	, ·	ation on 7-10-12 at					
	2:22 P.M.	ation on 7-10-12 at					
	Z.ZZ P.IVI.						
	l <u>-</u>						
	d) The physic	ian was notified.					
	e) Twenty res	ident interviews were					
	conducted usin	ig the QIS (Quality					
		vey) abuse tool on alert					
	and oriented re	• ,					
		olderite.					
	f) Civeta and accom	rant facility naves and					
	,	rent facility personnel					
	were interviewe	ed.					
	Review of a cu	rrent facility policy and					
	procedure date	ed February 2010 titled					
	l ·	tion, Reporting and					
		which was provided by					
	i iivesiigalioii v	villoti was provided by					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 2/2012
	PROVIDER OR SUPPLIER		170 N T	ADDRESS, CITY, STATE, ZIP RACY ST E, IN 46770	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the Administrate 12:36 P.M., incommunities to from abuse incommunities, abuse, reglect	or on 7-11-2012 at licated the following: of American Senior protect residents luding physical abuse, werbal abuse, mental, involuntary seclusion, riation of resident		CROSS-REFERENCED TO THE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	A. BUILDING 00		COMPLETED	
		155673	B. WIN			07/12/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				FRACY ST		
MARKLE	HEALTH & REHAE	BILITATION			E, IN 46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	A83.15(a) DIGNITY AND R INDIVIDUALITY The facility must in a manner and maintains or enh and respect in fu individuality. Based on interv review, the faci staff treated res and dignity in 1 interviews for re sample of 40. Findings includ During an interv on 7-9-2012 at Resident indicate with respect an Resident indicate the Resident up the Resident re previously bein 3 hour period. indicated the re done roughly b was unable to i member or who occurred. The Resident in	promote care for residents in an environment that ances each resident's dignity II recognition of his or her view and record lity failed to ensure the sidents with respect of 14 resident espect and dignity in a (Resident #98) e: view with Resident #98 11:06 A.M., the ated not being treated and dignity. The ated staff wanted to get to to sit in the chair and afused due to g left in the chair for a Resident #98 nove to the chair was y staff. Resident #98 dentify the staff en the incident and wanted the	F02		F241It is the practice of this facility to promote care for residents in a manner & in an environment that maintains or enhances each resident's dign & respect in full recognition of or her individuality. I. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Facility management immediately suspended an employee, pend further investigation of the allegation. Upon completion of thorough investigation, the allegation was determined to be unsubstantiated & the employed was permitted to return to world Upon conclusion of the investigation, facility managem submitted a Follow-up Report ISDH on 7-13-12. II. How will other residents having the potential to be affected by the same deficient practice be identified & what corrective action(s) will be taken: Employees were re-educated on Resident Righ The inservice will be complete by 8-11-12 & conducted by DNS/designee.III. What measures will be put into place.	his his nts y ding f a be ee k. nent to	08/11/2012

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Facility ID: 000544

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPLETED	
		155673		LDING		07/12/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	2					
MADICE		DILITATION.			FACY ST		
MARKLE	HEALTH & REHA	BILITATION		MARKL	E, IN 46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	The Administra	ator was notified of the			what systemic changes will be	· · · · · · · · · · · · · · · · · · ·	
	incident in an i	nterview on 7-9-2012			made to ensure that the deficient		
	at 11:29 A. M. Resident #98's clinical record was				practice does not recur: Memb	pers	
					of the IDT team will conduct		
					resident interviews using the		
					question in section C (Dignity) listed on the CMS form titled		
	reviewed on 7-	10-2012 at 3:17 P.M.			Resident Interviw & Resident		
					Observation. Interviews will be	e	
		diagnoses included			conducted on all "interviewable		
	but are not limi	ted to meningioma,			residents by 8-11-12. Any		
	hypertension, anemia, hyperlipidemia, dyspnea, fatigue, seizure disorder, insomnia, gastrointestinal reflux				negative findings will be		
					immediately reported to the		
					facility Administrator/DNS &		
	1	Chronic obstructive			investigated. During the month	_	
		-			resident council meetings, the		
	l .	ease, CHF (congestive			Administrator or another invite	d	
	· · · · · · · · · · · · · · · · · · ·	depression, coronary			IDT member will encourage		
	artery disease,	weight loss.			residents to voice any concerr they may have regarding abus	· · · · · · · · · · · · · · · · · · ·	
					mistreatment, or	, , , , , , , , , , , , , , , , , , ,	
	Resident #98 s	scored a 15 of 15 for			misappropriation. IDT member	rs	
	the brief intervi	ew mental status			will be responsible to conduct		
	(BIMS) on the	Minimum Data Set			monthly Family Interviews. At	the	
	assessment (M	1DS) dated 5-9-2012,			time of each interview, the IDT	-	
	6-19-2012 and	•			member will encourage reside		
					to voice any concerns they ma	ay	
	3.1-3(t)				have regarding abuse,		
	ο. 1-3(ι <i>)</i>				mistreatment, or		
					misappropriation. Family interviews will be conducted in		
					conjunction with our already		
					established Customer Care		
					program & will be done		
					monthly.IV. How will the		
					corrective action(s) be monitor	red	
					to ensure the deficient practice	e	
					will not recur, i.e., what quality		
					assurance program will be put	· · · · · · · · · · · · · · · · · · ·	
					into place: DNS/designee will		
					responsible for completion of t	he	
					CQI tool titled "Resident		

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MARKLE HEALTH & REHABILITATION (NA) ID SUMMARY STATIMANT OF DIFFICENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TO NOTACY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Interview*. The audit tool will be completed weekly x 4 weeks, then monthly x 6 monthls. Trends or findings will be submitted to the CQI committee for review & follow-up-ly. By what date will the systemic changes be completed: 8-11-12.		T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 07/1	E SURVEY PLETED 2/2012	
MARKLE HEALTH & REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (INTERVIEW). The audit tool will be completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed:	NAME OF P	ROVIDER OR SUPPLIER	2					
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Interview". The audit tool will be completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed:		HEALTH & REHA	BILITATION					
completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed:	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX			COMPLETION	
					Interview". The audi completed weekly x of then monthly x 6 more or findings will be sufficed committee for refollow-up.V. By what systemic changes be	t tool will be 4 weeks, nths. Trends bmitted to the eview & t date will the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
		155673	B. WING		07/12/2012
	PROVIDER OR SUPPLIE		170	ET ADDRESS, CITY, STATE, ZIP CODE N TRACY ST RKLE, IN 46770	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0282 SS=D	CARE PLAN The services pr facility must be in accordance v plan of care. Based on obsorecord review, provide dental residents revie and services in (Resident # 7) Findings include Resident # 7's reviewed on 7. Resident # 7's but were not li vascular accide Parkinson's dia Resident # 7 Minimum Data which indicate interview of m score of 13 to resident is coo MDS also refle needs extensi personal hygie Resident # 7's	clinical record was /10/12 at 2:43 p.m. diagnoses included, mited to cerebral ent (stroke), arthritis, sease. had a current, 5/25/12 a Set assessment d a BIMS (brief nental status) of 15, a 15 indicates that the gnitively intact. The ects that the resident we assistance with	F0282	F282It is the practice of this facility to provide for or arrange for services provided by qualipersons in accordance with exesident's written plan of care What corrective action will be accomplished for those reside found to have been affected the deficient practice: The affected resident is offered decare twice daily. Resident's Casheet was updated to reflect resident is to be offered dentacare twice daily. II. How are cresidents having the potential be affected by the same deficient practice identified & what corrective action(s) will be taken: Nursing staff were inserviced on dental care. The inservice will be conducted by DNS/designee & completed the 8-11-12. III. What measures who put into place or what systic changes will be made to ensuthat the deficient practice does not recur: C.N.A. assignment sheets have been updated to indicate those residents who need dental care. C.N.A.s are now required to document provision of dental care twice daily. Documentation will also include any resident refusals. A list of residents were	fied achl. ents by ental N.A. that al ether lito sient ne y y will emic are ess

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			
		155673	A. BUILDING B. WING		07/12/2012	
			_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		TRACY ST		
MADKIE	HEALTH & REHA	BII ITATION		(LE, IN 46770		
	. IILALIII & INLIIA	BILITATION	IVIAIXI			
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	·	DATE	
		ave her teeth brushed 2		are to receive mouth care will		
	times a day.			provided to the charge nurse each hall. The charge nurse		
				verify that proper oral care ha		
	During an inter	view, on 7/9/12 at 2:46		been provided & document or		
	p.m. with Resid	dent 7, she indicated		log. The completed log will b	e	
	her teeth were	brushed twice a week.		turned into the DNS weekly for	or	
				review & any needed		
	During an observation, on 7/8/12 at 5: 00 p.m., Resident # 7 was in the dining room awaiting supper. Her teeth had white material at the gum line.			follow-up. IV. How will the	urod	
				corrective action(s) be monitor to ensure the deficient practic		
				will not recur, i.e., what quality		
				assurance program will be pu		
				into place: DNS/designee will		
				responsible for completion of	the	
	During on ohoo	orietion on 7/0/12 et		CQI audit tool titled "Dental	.	
	_	ervation, on 7/9/12 at		Services". This audit tool will	be	
	•	sident # 7's teeth had		completed weekly x 4 weeks, then monthly x 6 months. Tre	ande	
		at the gum line and		or findings will be submitted to		
	gums were red	l and swollen.		CQI committee for review &		
				follow-up.V. By what date wil	I the	
	_	ervation and interview,		systemic changes be complete	ted:	
	on 7/10/12 at 2	2:00 p.m. Resident # 7		8-11-12		
	indicated she h	nad not had her teeth				
	brushed today	. The resident's teeth				
	were discolore	d and her gums were				
	red and swolle	n.				
	During an obse	ervation, on 7/10/12 at				
		sident # 7's teeth had				
	•	nce at the gum line and				
		e red and swollen.				
	Tale gails well	, rea and swonen.				
	During an inter	view, on 7/12/12 at				
		·				
	•	esident # 7 indicated				
		not brushed this				
	1	tooth brush on the bed				
	side stand app	eared dry and the 2				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY MPLETED 12/2012
	PROVIDER OR SUPPLIER E HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	other toothbrushes in her drawer also appeared to be dry.				
	During an interview, on 7/12/12 at 10: 35 a.m., The Administrator indicated the facility did not have a policy for a.m. and p.m. care. The facility used the skills check off for CNA (Certified Nurse Assistant) which indicated the residents should get assistance with oral hygiene in the a.m. and in the p.m. 3.1-35(g)(1)				

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record review, the facility failed to ensure food was served at a palatable temperature for 4 of 14 residents interviewed with the potential to affect 17 residents receiving delivered meal trays in their rooms and 25 residents receiving meal trays delivered to "The Cottage" (Memory Care Unit). (Resident # 62, 78, 87, 98) Findings include: Findings include: 1. During resident interviews conducted on 7/9/12 and 7/10/12, 4 of 14 residents interviewed indicated food items were not served at proper temperatures. (Residents # 62, 78, 87, 98) Interview with Resident # 87 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold. Interview with Resident # 62 on 7/9/12 at Interview with Resident #	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION X4) ID TAG SUMMARY STATEMENT OF DEFCIENCIES TAG SUSMARY STATEMENT OF DEFCIENCIES TAG TON TRACY ST MARKLE, IN 46770 TAG TOS TAG TAG TOS TA	AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		а віл	LDING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION IN TRACY ST MARKLE, IN 46770		155673					07/12/2012	
MARKLE HEALTH & REHABILITATION (X4) ID PRETIX TAG RECOLLATORY OR LSC INSTITUTION SUMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC INSTITUTION INFORMATION) FOOSSE REFERENCE TO THE APPROPRIATE FOOSSE AS SEE FOOSSE AS SEE FOOSSE AS SEED TO THE APPROPRIATE FOOSSE AS SEED TO THE APPROPRIATE FOOSSE AS SEED TO THE APPROPRIATE ASS SEE FOOSSE AS SEED TO THE APPROPRIATE FOOSSE AS SEED TO THE APPROPRIATE COMPLETION DATE COMPLETION DATE COMPLETION CONSESTER RECOLLED TO THE APPROPRIATE COMPLETION DATE FOOSSE AS SEED TO THE APPROPRIATE COMPLETION COMPLETION DATE COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION DATE FOOSSE AS SEED TO THE APPROPRIATE COMPLETION	NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICENCIES 1D PROVIDES IN AND GEORGETTON COMPLETION	NAME OF PROVIDER OR SUPPLIER				170 N T	TRACY ST		
FOSSA SS=E PREFIX TAG REGULATORY OR I.SC IDENTIFYING INFORMATION) FOSSA SS=E AVAILATE REGULATORY OR I.SC IDENTIFYING INFORMATION) AVAILATE REGULATORY OR I.SC IDENTIFYING INFORMATION) FOSSA SS=E AVAILATE REGULATORY OR I.SC IDENTIFYING INFORMATION FOSSA SAPEREMCENCO TO BE APPROPRIATE FOSSA FOSSA SAPEREMCENCO TO BE APPROPRIATE FOSSA FOSSA SAPEREMCENCO FOSSA SAPEREMCENCO TO BE APPROPRIATE FOSSA FOSSA SAPEROPLEOUS OR INC. FOSSA SAPEREMCENCO FOSSA SAPEREMCENCO FOSSA SAPEREMCENCO FOSSA SAPEREMCENCO FOSSA SAPEREMCENCO FOSSA SAPEROPLEOUS FOSSA SAPILATION FOSSA SAPILATION FOSSA SAPILATION	MARKLE HEALTH & REHABILITATION					E, IN 46770		
FO364 SS=E REGULATORY OR ISC IDENTIFYING INFORMATION) TAG REGULATORY OR ISC IDENTIFYING INFORMATION TAG REGULATORY OR IS INFORMATION TAG REGULATORY OR ISL INFORMATION TAG TAG REGULATORY OR ISL INFORMATION TAG TAG TAG TAG TAG TAG TAG TA	` ′							` ′
F0364 SS=E A33.36(a)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 4 of 14 residents interviewed with the potential to affect 17 residents receiving delivered meal trays in their rooms and 25 residents receiving meal trays delivered to "The Cottage" (Memory Care Unit). (Resident #62, 78, 87, 98) Findings include: 1. During resident interviews conducted on 7/9/12 and 7/10/12, 4 of 14 residents interviewed indicated food items were not served at proper temperatures. (Residents # 62, 78, 87, 98) Interview with Resident # 87 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold. Interview with Resident # 62 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold. Interview with Resident # 62 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold.		`				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 4 of 14 residents interviewed with the potential to affect 17 residents receiving delivered meal trays in their rooms and 25 residents receiving meal trays delivered to "The Cottage" (Memory Care Unit). (Resident # 62, 78, 87, 98) Findings include: 1. During resident interviews conducted on 7/9/12 and 7/10/12, 4 of 14 residents interviewed indicated food items were not served at proper temperatures. (Residents # 62, 78, 87, 98) Interview with Resident # 87 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 62 on 7/9/12 at 1. Interview with Resident # 63 on 7/9/12 at 1. Interview with Resident # 64 on 7/9/12 at 1. Interview with Resident # 64 on 7/9/12 at 1. Interview with Resident # 64 on 7/9/12 at 1. Interview with Resident # 64 on 7/9/12 at 1. Interview with Resident #			LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
occasionally warm. temps. Inservice will be completed by 8-11-12. III. What	F0364	483.35(d)(1)-(2) NUTRITIVE VAL PALATABLE/PR Each resident re provides food pre conserve nutritive appearance; and attractive, and at Based on observer record review, the food was served temperature for 4 interviewed with residents receiving their rooms and 4 meal trays delived (Memory Care US7, 98) Findings include 1. During reside on 7/9/12 and 7/2 interviewed indicate on 5/2 a.m. indicate of 10:31 a.m. indica	LUE/APPEAR, EFER TEMP ceives and the facility epared by methods that e value, flavor, and a food that is palatable, the proper temperature. Action, interview and the facility failed to ensure at a palatable at a palatable at a palatable at the potential to affect 17 and delivered meal trays in 25 residents receiving the ered to "The Cottage" (Init). (Resident # 62, 78, Init). (Resident # 62, 78, Init). (Resident # 87 on 7/9/12 at ed the hot food is not did, and even the soup is esident # 62 on 7/9/12 at eated the food is	F03		F364lt is the practice of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritiv value, flavor, and appearance; and to serve food that is palatable, attractive, and at the proper temperature.l. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Dietary manager/designee is testing the food for proper temps. The frequency of taking food temps has been increased to 1. at the beginning of trayline service, 2 just prior to the food cart leaving the kitchen, and 3. after the last meal of the delivery cart has been served. Dietary manager/designee is recording these temps on a log.II. How too their residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken. Facility dietician will inservice dietarys regarding the requirement to serve food at the proper food temps. Inservice will be	e e e e nts y ne s ne c s ne will	08/11/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
155673		B. WING			07/12/2012			
			B. WIN		ADDRESS CITY STATE ZIR CODE			
NAME OF F	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE			
			170 N TRACY ST					
WARKLE	HEALTH & REHA	BILITATION		MARKL	E, IN 46770			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMP	LETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		ATE	
					measurees will be put into place	e l		
	Interview with R	esident # 98 on 7/9/12 at			or what systemic changes will			
		ated the food is cold.			made to ensure that the deficie			
		ated the food is cold.			practice does not recur: Cold f			
					items & cold beverages will be			
		esident # 78 on 7/9/12 at			kept refrigerated until immedia			
	4:32 p.m. indicat	ted the food is usually			before the doors are closed or the food delivery carts. The co			
	cold, by the time	it get to us in The			items/cold beverages will be the			
	Cottage.				last items placed on each tray.			
					This will enable the cold items			
					be served at the proper cold			
	2 D : 1	·			temperature. Fluids will be			
		vation of meal tray			provided for the Cottage reside	ent		
	1 ^ ^	/10/12 at 11:00 a.m., it			meals in pitchers & Cottage st			
	took 25 minutes	to complete 25 trays for			will pour their own drinks. The			
	The Cottages. Th	ne Cambro Cart (food			pitchers will be filled & delivered			
	_	at 11:30 a.m. to be			by dietary personnel/designee			
	delivered to				the Cottage prior to meal servi	ce		
		minutes often finat lunch			and stored in the Cottage refrigerator until meal			
	_	minutes after first lunch			time. Dietary manager will ens	ure		
	1 - 1	n plate and stored in			that each hot food item is put of			
	delivery cart.				plate that has been thoroughly			
					heated & will immediately cover			
	3. During observ	vation of meal tray			the food in order to properly re	tain		
	preparation for T	The Cottage on 7/11/12 at			the hot temperature. The Diet	•		
	11:00 a.m., it too	•			manager will reorganize our tra	-		
		al trays. At 11:23 a.m.			line service procedure in order			
	-	-			speed up the efficiency of mea			
		tary Manager #1 pulled			service. RD will audit/evaluate this procedure on her regular	'		
		tray completed and			facility visits. The dining room			
	stored in the Car	nbro to measure food			managers/designee will be			
	temperatures. T	he Dietary Manager's			responsible for completion of t	ne		
	thermometer ind	icated the following food			Food Quality Evaluation form f			
		illed chicken pasta salad,			each meal. Completed form w			
	chicken breast strips was 89 degrees, lettuce and pasta was 75 degrees, dices				be submitted to the ED/design	ee		
					for review & necessary			
					follow-up. Dietary			
	•	egrees, milk was 51.1			Manager/designee will be			
	degrees, and the	apple juice was 52.9			responsible to conduct a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155673		A. BUILDING	DEE CONSTRUCTION 00	COM	TE SURVEY PLETED 2/2012			
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION			B. WING 07/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770					
	SUMMARY S' (EACH DEFICIEN REGULATORY OR degrees. 4. On 7/12/12 at dining room obse checks with the I Dietary Manager indicated the foll diced pears 49.6 degrees and chic pasta 65 degrees 5. Review of a condition of the condit	ATTEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 12:15 p.m., during ervation of temperature Dietary Manager #1, the 's thermometer owing temperatures: degrees, milk 41.7 ken Caesar salad with current facility policy d "Food Temperatures" ded by the Dietary /12 at 12:30 p.m., llowing: are potentially hazardous chen (or steam table)	170	O N TRACY ST ARKLE, IN 46770 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	orrection or should be e appropriate ormly selected sing the QP249 (Food CMS form iew & n. Interviews onthly x 6 re findings essed & etary rill be eletion of a Service". completed en monthly x t date will the	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED		
155673		155673	A. BUILDING B. WING			07/12/2012		
			B. WING		DDDFGG CITY CTATE ZID CODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
MARKLE HEALTH & REHABILITATION			170 N TRACY ST MARKLE, IN 46770					
WARKLE	HEALTH & REHAL	BILITATION		WARKL	E, IN 46770			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0431 SS=D	483.60(b), (d), (e) DRUG RECORE & BIOLOGICALS The facility must services of a lice establishes a sys and disposition of sufficient detail to reconciliation; ar records are in or controlled drugs periodically reco Drugs and biolog be labeled in acc accepted profess the appropriate a instructions, and applicable. In accordance w the facility must biologicals in loc proper temperate authorized person keys. The facility must permanently affir storage of control II of the Comprel	e) OS, LABEL/STORE DRUGS Seemploy or obtain the ensed pharmacist who stem of records of receipt of all controlled drugs in one enable an accurate and determines that drug der and that an account of all is maintained and inciled. Gicals used in the facility must cordance with currently sional principles, and include accessory and cautionary the expiration date when the store all drugs and ked compartments under the controls, and permit only onnel to have access to the provide separately locked, and compartments for olled drugs listed in Schedule thensive Drug Abuse						
	drugs subject to facility uses sing distribution syste	Control Act of 1976 and other abuse, except when the le unit package drug ems in which the quantity I and a missing dose can be						
	facility failed to properly	ation and interview, the ensure an insulin pen was e opened for 1 of 1 insulin	F04:	31	F431lt is the practice of this facility to employ or obtain the services of a licensed pharmac who establishes a system or records of receipt and disposit		08/11/2012	

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	д ріші	DING	00	COMPLETED	
		155673	A. BUILDING B. WING			07/12/2012	
			D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					TRACY ST		
MARKLE HEALTH & REHABILITATION					E, IN 46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	pens reviewed st	fored in 1 of 3 medication			of all controlled drugs in suffic	ient	
	carts. The facility	ty also failed to properly			detail to enable an accurate		
	dispose of an exp	pired bottle of medication			reconciliation; and to determin		
	stored in 1 of 3 r	•			that drug records are in order and that an account of all controlled		
	reviewed.				drugs is maintained & periodic		
	Teviewed.				reconciled.It is the practice of		
	F: 1: : 1 1				facility to ensure that drugs &		
	Findings include): 			biologicals used in the facility are		
					labeled in accordance with		
	On 7/12/12 at 9:	47 a.m., during a			currently accepted professiona	al	
	medication stora	ge tour with the DoN,			principles & include the		
	while observing	medication storage, the			appropriate accessory & cautionary instructions, and th	_	
	medication cart i	in the 200 hall was found			expiration date when applicab		
	to have a bottle of	of Hydrocodone			is the practice of this facility to		
		d to treat pain) containing			ensure, in accordance with Sta		
	`	. ,			& Federal laws, that the facility	/	
	2 72 tablets that 6	expired on 5/31/12.			stores all drugs & biologicals i	n	
					locked compartments under		
		50 a.m., the medication			proper temperature controls, &		
	cart on the 300 h	all was found to have a			permit only authorized person to have access to the keys.It is		
	Lantus SoloStar	insulin pen (medication			the practice of this facility to	·	
	used to lower blo	ood sugar) with no date			provide separately locked,		
	on the pen when				permanently affixed		
	1	•			compartments for storage of		
	 Interview on 7/1	2/12 at 11:37 a.m., the			controlled drugs listed in		
					Schedule II of the Comprehen	sive	
		ne representative from the			Drug Abuse Prevention and		
		nacy was in the facility			Control Act of 1976 and other drugs subject to abuse, excep	,	
	6/19/12 to review medications. The DoN indicated the medication should be dated when opened and should be disposed when expired.				when the facility uses single u		
					package drug distribution		
					systems in which the quantity		
					stored is minimal and a missin		
					dose can be readily detected.l		
	During an interv	iew on 7/12/12 at 2:50			What corrective action(s) will be		
	_				accomplished for those reside		
	p.m., the ADON indicated the Lantus insulin pen was almost full and just opened 2 days prior to the medication				found to have been affected b		
					the deficient practice: The insupen was destroyed. The expire		
					pen was desiroyed. The expire	z u	

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	of correction (X1) Provider/supplier/clia (IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2012			
	PROVIDER OR SUPPLIER E HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	2.112			
	storage observation by an RN who was currently off. She indicated the Hydrocodone was discontinued before the expiration date on the bottle according to physician orders and the resident did not receive any additional doses of medication. 3.1-25(o) 3.1-25(e)(3)		medication was destroyed or 7-12-12.II. How will other residents having the potential be affected by the same deficing practice be identified and what corrective action(s) will be taken: Licensed nurses will be re-educated on proper medication when opened and discarding expired medications). Inservice will be conducted by DNS/designee & completed & 8-11-12.III. What measures when the deficient practice does not recur: A llicensed nurse of each hallway will audit their nucart for expired meds & improperly labeled meds at the end of each shift & document review on a log. The completed log will be turned the DNS for review & follow-up.IV. How will the corrective action(s) be monited to ensure the deficient practice will not recur, i.e., what quality assurance program will be pure into place:DNS/designee will responsible for completion of CQI tool titled "Medication Storage Review". The audit will be completed monthly x & months. Trends or findings where the deficient practice will be completed monthly x & months. Trends or findings where the completed monthly x & months. Trends or findings where the completed monthly x & months. Trends or findings where the completed monthly x & follow-up.V. By what date with systemic changes be completed to the CQI committee for review & follow-up.V. By what date with systemic changes be completed.	I to cient at e ation ins ice by will temic cure es on ined into cred ce by ut be the tool of the the the tool of the			

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